# STATE PLAN AMENDMENT
# PROSPECTIVE PAYMENT REIMBURSEMENT

A. General Applicability

1. Notwithstanding any other provision of this State Plan, reimbursement to all Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for the types of services described in this Amendment will be made as set forth below. This Amendment will apply to Medi-Cal Services furnished to Medi-Cal beneficiaries for purposes of implementing Section 1902(bb) of the Social Security Act (the Act).

2. Under the California Section 1115 Medicaid Demonstration Project for Los Angeles No. 11 W-00076/9 (LA Waiver), specified FQHCs (or "FQHC look alike clinics") received 100 percent cost-based reimbursement under the Special Terms and Conditions of that waiver. Beginning July 1, 2005, FQHCs that received cost-based reimbursement under the LA Waiver will be paid under the methodology described under Section I.

3. Any facility that first qualified as an FQHC or RHC (as defined in Section B) prior to the close of its fiscal year ending in calendar year 2000 was reimbursed through the prospective payment methodology described under Section D, unless, within 30 days of written notification from DHS, the facility elected to be reimbursed under the alternative payment methodology described under Section E. If the alternative payment methodology described under Section E was selected by the facility, the initial selection of a payment methodology remained in effect through September 30, 2002.

4. Prior to October 1, 2002, each FQHC and RHC was required to choose a reimbursement method and to inform DHS of its election. The choice was whether its reimbursement rate calculation, which was to serve as the basis for all future Medicare Economic Index (MEI) increases and scope-of-service changes, would be either of the following:

   (1) The prospective payment reimbursement methodology described under Section D.

   (2) The alternative payment reimbursement methodology described under Section E.

For purposes of this segment of the State Plan, relating to prospective reimbursement for FQHCs and RHCs, the MEI is the annual percentage increase in costs as defined in Section 1842(i)(3) of the Act for primary care services, defined in Section 1842(i)(4) of the Act. The MEI is published each year in the Federal Register. The base rate selected for purposes of reimbursement under the methodology described under Section D or Section E is inclusive of the MEI increases that applied prior to October 1, 2002, as described under Section D and Section E. An FQHC or RHC that failed to notify DHS of its election of the alternative payment methodology within 30 days of written notification was assigned a reimbursement rate calculated using the prospective payment methodology described under Section D.

5. Provider-based entities are defined as the following:

(a) An FQHC that was provider-based as of July 1, 1998, or that had provider-based status pending on April 22, 1999, and has received Medi-Cal payments based on its provider-based status continuously since that date, was paid under either the prospective payment methodology (Section D) or the alternative payment methodology (Section E), as appropriately adjusted in accordance with its FQHC provider-based status. The term "appropriately adjusted" means that an FQHC's provider-based rate includes the amount of the hospital's total costs allocable to the FQHC. These costs are in addition to those costs directly attributable to the operation of the FQHC site, and do not include inpatient hospital costs that have been, or should have been, included in the hospital cost reports.

If an FQHC receives "FQHC provider-based" designation under Medicare, pursuant to 42 CFR Part 413.65(n), from CMS, the FQHC may apply to DHS for Medi-Cal provider-based FQHC reimbursement status. Upon verification of such status, the FQHC will be paid under the new facility's rate setting methodology (Section J), as appropriately adjusted in accordance with its FQHC provider-based status.

(b) In accordance with 42 CFR Section 491.3, an RHC that received provider-based designation and RHC certification under Medicare from CMS as a "provider-based RHC", will continue to be paid under either the prospective payment methodology (Section D), or the alternative payment methodology (Section E), as appropriately adjusted in accordance with its RHC provider-based status. The term "appropriately adjusted" in this context means that an RHC's provider-based rate includes the amount of the hospital's shared costs allocable to the RHC. These costs are in addition to those

costs directly attributable to the operation of the RHC site, and do not include inpatient hospital costs that have been, or should have been, included in the hospital cost reports.

If subsequent to the approval of this State Plan Amendment, an RHC receives provider-based designation and RHC certification under Medicare from CMS as a "provider-based RHC", pursuant to 42 CFR Part 41 3.65, the RHC may apply to DHCS for Medi-Cal provider-based RHC reimbursement status pursuant to 42 CFR Part 491.3. Upon verification of such status, the RHC will be paid under the new facility's rate setting methodology (Section J), as appropriately adjusted in accordance with its RHC provider-based status.

6. An FQHC or RHC may elect to have pharmacy services reimbursed on a fee-for-service basis, utilizing the current fee schedules established for those services. An FQHC or RHC that elects to have pharmacy services reimbursed on a fee-for-service basis will not have its reimbursement rate for those services converted to a fee-for-service basis until the FQHC or RHC completes a scope-of-service rate change request and the adjustment to the prospective payment system reimbursement rate has been completed. An FQHC or RHC that reverses its election under this provision will revert to its prior rate, subject to an increase to account for all MEI increases occurring during the intervening time period adjusted for any increase or decrease associated with an applicable scope-of-service change as provided in Section K.

B. FQHCs and RHCs Eligible for Reimbursement Under This Amendment

FQHCs and RHCs eligible for prospective or alternative payment reimbursement are those defined as a "Federally Qualified Health Center" or "Rural Health Clinic" in Section 1905(1)(2)(B), and Section 1905(1)(1), respectively, of the Act.

C. Services Eligible for Reimbursement Under This Amendment

1. (a) Services eligible for prospective or alternative payment reimbursement are covered benefits described in Section 1905(a)(2)(C) of the Act that are furnished by an FQHC and services described in Section 1905(a)(2)(B) of the Act that are furnished by an RHC. The services furnished will be reported to DHCS annually, in a format prescribed by DHCS.

(b) Optional services that are furnished by an FQHC and RHC within the scope of subparagraph C.1(a), or any other provision of this State Plan, are covered only to the extent that they are identified in the State Plan segments titled, "Limitations on Attachment 3.1-A" and "Limitations on Attachment 3.1-B" on pages 3 through 3e, effective July 1, 2016.

2. A "visit" for purposes of reimbursing FQHC or RHC services includes any of the following:

(a) A face-to-face encounter between an FQHC or RHC patient and a physician, a resident in a Teaching Health Center Graduate Medical Education Program under the supervision of a teaching physician (effective 04/01/2018), physician assistant, nurse practitioner, acupuncturist, certified nurse

midwife, clinical psychologist, licensed clinical social worker, dental hygienist, a dental hygienist in alternative practice, marriage and family therapist, or visiting nurse, hereafter referred to as a "health professional," to the extent the services are reimbursable as covered benefits under C.I.(a). For purposes of this subparagraph 2(a), "physician" includes the following:

(i) A doctor of medicine or osteopathy licensed by the State to practice medicine and/or surgery and who is acting within the scope of his/her license.

(ii) A doctor of podiatry licensed by the State to practice podiatric medicine and who is acting within the scope of his/her license.

(iii) A doctor of optometry licensed by the State to practice optometry and who is acting within the scope of his/her license.

(iv) A chiropractor licensed by the State in the practice of chiropractic and who is acting within the scope of his/her license.

(v) A doctor of dental surgery (dentist) licensed by the State to practice dentistry and who is acting within the scope of his/her license.

Inclusion of a professional category within the term "physician" is for the purpose of defining the professionals whose services are reimbursable on a per visit basis, and not for the purpose of defining the types of services that these professionals may render during a visit (subject to the appropriate license).

(b) Comprehensive perinatal services when provided by a comprehensive perinatal services practitioner.

3. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit. More than one visit may be counted on the same day (which may be at a different location) in either of the following situations:

   (a) When the clinic patient, after the first visit, suffers illness or injury requiring another diagnosis or treatment, two visits may be counted.

   (b) The clinic patient has a face-to-face encounter with a dentist and then also has a face-to-face encounter with any one of the following providers: physician (as defined in subparagraphs C.2(a)(i)-(iv)), physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, licensed clinical social worker, visiting nurse, or a comprehensive perinatal services practitioner.

D. Prospective Payment Reimbursement

An FQHC or RHC that does not elect the alternative payment reimbursement methodology under Section E will receive reimbursement under the following prospective payment reimbursement methodology provisions:

1. On July 1, 2001, DHS implemented a prospective payment reimbursement methodology on a phased-in basis. Each FQHC or RHC receives payment in an amount calculated using the methodology described under paragraphs D.2 and D.4 effective the first day of the fiscal year on or after July 1, 2001. For the period January 1, 2001, until the payment methodology described in this Section D became effective for a particular facility, each FQHC or RHC was paid in accordance with Section H.

2. (a) Beginning on January 1, 2001, the prospective payment reimbursement rate for an FQHC or RHC was equal to 100 percent of the average reported cost-based reimbursement rate per visit for fiscal years 1999 and 2000 for the FQHC or the RHC, as determined in accordance with cost reimbursement principles for allowable costs explained in 42 CFR Part 413, as well as, Generally Accepted Accounting Principles. For each FQHC or

RHC, the prospective payment reimbursement rate for the first fiscal year was calculated by adding the visit rate for fiscal years 1999 and 2000, and then dividing the total by two.

(b) If the cost per visit for the period(s) used to establish the prospective payment reimbursement rate in subparagraph D.2(a) was calculated using a visit definition that does not conform to Section C, the FQHC or RHC must submit a revised visit count and supporting documentation that conforms with Section C. The FQHC or RHC must supply the revised visit count with supporting documentation and certify to its authenticity within 90 days after the date written instructions are issued by DHS. DHS must review the revised visit count and supporting documentation supplied by the FQHC or RHC to determine whether a rate adjustment was necessary. This subparagraph D.2(b) was applicable to either a FQHC or a RHC that established its PPS reimbursement rate for fiscal years 1999 and 2000 exclusively.

3. Services provided at intermittent service sites that are affiliated with an FQHC or RHC that operate less than 20 hours per week, or mobile facilities are reimbursed at the rate established for the affiliated FQHC or RHC. For purposes of this paragraph, a facility is affiliated with an FQHC or RHC when the facility is owned or operated by the same entity, as well as, licensed or enrolled as a Medi-Cal provider.

4. Effective October 1st of each year, for services furnished on and after that date, DHS will adjust the rates established under paragraph D.2 by the percentage increase in the MEI applicable to primary care services (as defined in Section 1842(i)(4) of the Act) as published in the Federal Register for that calendar year.

5. DHS will notify each FQHC and RHC of the effect of the annual MEI adjustment.

E. Alternative Payment Methodology Using the Reported Cost-Based Rate for the Fiscal Year Ending in Calendar Year 2000

An FQHC or RHC that elected the alternative payment methodology under this Section E receives reimbursement under the following provisions:

1. Each FQHC and RHC that elected to receive payment in an amount calculated using the alternative payment methodology described in this Section E, the rate was effective the first day of the fiscal year that began on or after January 1, 2001. For the period January 1, 2001, until the payment methodology described in this Section E became effective for the

particular facility, the FQHC or RHC was paid in accordance with Section H.

(a) Payments made to each FQHC or RHC in accordance with the alternative payment reimbursement methodology set forth in this Section E will be an amount (calculated on a per-visit basis) that is, equal to its reported cost-based rate (based on allowable costs) for the particular facility's fiscal year ending in calendar year 2000, increased by the percentage increase in the MEI. DHS determines all rates in accordance with cost reimbursement principles in 42 CFR Part 413, and with Generally Accepted Accounting Principles.

(b) (i) Each participating FQHC's or RHC's reported cost-based reimbursement rate (calculated on a per-visit basis) for the particular facility's fiscal year ending in calendar year 2000 serves as its prospective payment reimbursement rate under the alternative payment reimbursement methodology.

(ii) If the cost per visit for the period used to establish the alternative payment methodology rate in subparagraph E.1(b)(i) was calculated using a visit definition that does not conform with Section C, the FQHC or RHC must submit a revised visit count and supporting documentation that conforms with Section C. The FQHC or RHC must supply the revised visit count with supporting documentation and certification of accuracy within 90 days after the date written instructions are issued by DHS. DHS must review the revised visit count and supporting documentation supplied by the FQHC or RHC in determining if a rate adjustment was necessary. Subparagraph E.1(b)(ii) was applicable to either a FQHC or a RHC that established its PPS reimbursement rate for fiscal years 1999 and 2000 exclusively.

(c) As described in more detail below, the prospective payment reimbursement rate is increased by the percentage increase in the MEI applicable to primary care services, defined in Section 1842(i)(4) of the Act, for the particular calendar year as published in the Federal Register.

(d) Beginning July 1, 2001 and thereafter, the MEI increase is applicable to the period starting with the mid-point of each FQHC's or RHC's fiscal year through the mid-point of the rate periods (January 1, 2001 through June 30, 2001 and July 1, 2001 through September 30, 2002).

For example, if a FQHC or RHC had a June 30th fiscal year end, the period determining the first MEI increase was December 31, 1999 (the FQHC's or RHC's fiscal year mid-point) through April 1, 2001 (the midpoint for the rate period January 1, 2001 through June 30, 2001). The period determining the second MEI increase was April 1, 2001 through February 15, 2002 (the midpoint for the rate period July 1, 2001 through September 30, 2002). If a FQHC or a RHC has a December 31st fiscal year end, the period determining the first MEI increase was June 30, 2000 through April 1, 2001. As in the previous example, the period determining the second MEI increase was April 1, 2001 through February 15, 2002.

(e) In accordance with Section 1902(bb)(6)(B) of the Act, in order for an FQHC or RHC to receive the rate of payment under the alternative payment methodology, the rate must be no less than the rate calculated using the methodology described in Section D.

2. Services provided at intermittent service sites that are affiliated with an FQHC or RHC that operate less than 20 hours per week or in mobile facilities are reimbursed at the rate established for the affiliated FQHC or RHC. For purposes of this paragraph, a facility is affiliated with an FQHC or RHC when it is owned or operated by the same entity and is licensed or enrolled as a Medi-Cal provider.

3. Beginning October 1, 2002, and each October 1st thereafter, for services furnished on and after October 1, 2002, DHS will adjust the rates established under paragraph E.1, by the percentage increase in the MEI (as specified in subparagraph E.1(c), above).

F. Alternative Payment Methodology for an Existing FQHC or RHC that Relocates

1. An existing FQHC or RHC that relocates may elect to have its prospective payment reimbursement rate re-determined. DHS will establish a rate (calculated on a per-visit basis) that is equal to either of the following (as selected by the FQHC or RHC):

(a) The average of the rates established for three comparable FQHCs or RHCs, as verified by DHS from information submitted as required under paragraph J.2. The prospective payment reimbursement rate established under this subparagraph is subject to the annual MEI increases as described in paragraph D.4.

(b) Reimbursement at 100 percent of the projected allowable costs of the facility for furnishing services in the facility's first full fiscal

year of the facility's operation at the newly relocated site. The projected allowable costs for the first fiscal year will be cost settled and the prospective payment reimbursement rate will be based on actual cost per visit. The prospective payment reimbursement rate, so established, will apply retrospectively to all services provided at the new site. After the facility's first fiscal year of operations at the new site, the prospective payment reimbursement rate established under this subparagraph, which is based on the projected allowable costs, will be subject to the annual MEI increases described in paragraph D.4.

2. A rate established for an existing FQHC or RHC under this Section F is effective for visits occurring at the new facility.

G. Payment Methodology for Extraordinary Circumstances

1. Supplemental payments, in proportion to the Medi-Cal services provided by the facility, may be established in accordance with this Amendment to reflect the net realized additional costs (as approved by DHS), not otherwise reimbursed by other sources, incurred as a result of extraordinary circumstances attributed to any of the following:

   (a) Acts of nature (e.g., flood, earthquake, lightning, or storms).

   (b) Acts of terrorism.

   (c) Acts of war.

   (d) Riots.

   (e) Changes in applicable requirements in the Health and Safety Code.

   (f) Changes in applicable licensing requirements.

   (g) Changes in state or federal laws or regulations applicable to FQHCs or RHCs.

2. The supplemental payment provided for in this Section G will apply only to the extent, and only for the period of time, that the additional costs for the event specified in paragraph G.1 are reimbursable under federal Medicaid law and regulations governing claims for federal financial participation.

3. Where applicable, the supplemental payment provided in this Section G will be governed by cost reimbursement principles identified in 42 CFR

Part 413, and to the extent not governed by Part 413, by Generally Accepted Accounting Principles.

4. A request for supplemental payment will be accepted by DHS at any time in the prospective payment rate year. A request will be submitted for each affected year. A written request under this Section G must be made to DHS for its consideration and must include differences in costs and visits, if applicable, associated with operations before and after the event specified in paragraph G.1. Documentation in a manner and form specified by DHS showing the cost implications must be submitted. A supplemental payment will not be paid unless the cost impact will be material and significant (two hundred thousand dollars ($200,000) or 1.0 percent of an FQHC's or RHC's total costs, whichever is less).

5. DHS will decide whether a request for supplemental payment will be granted, and the amount of such payment. Amounts granted for supplemental payment requests will be paid as lump-sum amounts for those years and not as revised PPS rates. The FQHC or RHC must repay the unspent portion of the supplemental payment to DHS if it does not expend the full amount of the supplemental payment to meet costs associated with the catastrophic event.

6. The supplemental payment provided in this Section G is independent of a rate adjustment resulting from a scope-of-service change in accordance with Section K and will only be made for a qualifying event as described in this Section G. Costs eligible for a supplemental payment under this Section will be proportionate to the Medi-Cal services provided by the facility, determined utilizing a cost report format as specified by DHS, and will not include payment for any costs recovered as scope-of-service rate change(s) under Section K.

7. When determining eligibility for a supplemental payment, the FQHC or the RHC must show that its PPS rate is not sufficient to cover the costs associated with the extraordinary circumstance. If the PPS rate is sufficient to cover the costs associated with the events specified in paragraph G.1, or the PPS rate was adjusted to compensate the events specified in paragraph G.1, then no supplemental payment will be made.

H. Alternative Payment Methodology for Retroactive Reimbursement

1. For the period January 1, 2001, until the date that a particular FQHC or RHC begins to receive payment pursuant to the methodology set forth in Section D or Section E, such FQHC or RHC may elect to retroactively receive reimbursement under Section D or Section E, or to decline such reimbursement. An FQHC or RHC that fails to make an election within 30 days of written notification from DHS will receive retroactive payment

to January 1, 2001, under the prospective payment methodology described under Section D.

2. An FQHC or RHC that elected in writing to decline retroactive reimbursement under both Section D and Section E may continue to be paid under the cost-based reimbursement methodology as in effect prior to BIPA 2000 until payments under Section D or Section E take effect, subject to the requirements of Section 1902(bb)(6) of the Act, and to cost reconciliation when appropriate.

I. Alternative Payment Methodology for FQHCs Participating Under the LA Waiver

1. The LA Waiver expired on July 1, 2005. FQHCs participating in the LA Waiver that were established as an FQHC (as defined in Section B) prior to 1999 and elected to remain under cost-based reimbursement must convert to a prospective payment system reimbursement rate, effective July 1, 2005. FQHCs as described above must choose one of the following options for calculating their prospective payment system reimbursement rate:

   (a) Utilize the average of their "as reported" FY 1999 and FY 2000 cost reports, plus adjustments for the annual MEI increases described under paragraphs D.2-5.

   (b) Utilize only the "as reported" FY 2000 cost report, plus adjustments for annual MEI increases as described under subparagraph E.1(a)-(e) and paragraph E.3.

2. On October 1, 2005 and each October 1st thereafter, DHS will adjust the rate established under subparagraphs I.1(a) or (b) by the applicable percentage increase in the MEI, as specified in paragraph D.4 or paragraph E.3.

3. Clinics participating in the LA Waiver that attained FQHC designation (as defined in Section B) after FY 1999, but prior to the close of their FY 2000 will have their prospective payment system reimbursement rate calculated according to the methodology described in subparagraph I.1(b) above, and will have their prospective payment system reimbursement rate adjusted in accordance with paragraph I.2 above.

4. Clinics participating in the LA Waiver that attained FQHC designation (as defined in Section B) after FY 2000 will have their prospective payment system reimbursement rate calculated based on the first full fiscal year "as audited" cost report adjusted by the applicable MEI increase(s) to bring the prospective payment system reimbursement rate current to July 1,

2005, and will also have their prospective payment system reimbursement rate adjusted in accordance with paragraph I.2 above.

5. FQHCs that failed to elect an option by June 30, 2005, under either subparagraphs I.1(a) or (b) above, will be assigned the prospective payment system reimbursement rate described in Section I.1(a).

6. FQHCs participating in the LA Waiver that had applicable scope-of-service change(s) prior to July 1, 2005, must submit a scope-of-service change request describing the qualifying event. FQHCs must submit a scope-of-service change request no later than July 1, 2006.

J. Rate Setting for New Facilities

1. For the purpose of this Section J, a new facility is an FQHC or RHC (as defined in Section B) that meets all applicable licensing or enrollment requirements, and satisfies any of the following characteristics:

   (a) First qualifies as an FQHC or RHC after its fiscal year ending on or after calendar year 2000.

   (b) A new facility at a new location is added to an existing FQHC or RHC and is licensed or enrolled as a Medi-Cal provider.

2. DHS will require that the new facility identify at least three comparable FQHCs or RHCs providing similar services in the same or an adjacent geographic area with similar caseload. If no comparable FQHCs or RHCs are in operation in the same or an adjacent geographic area, the new facility will be required to identify at least three comparable FQHCs or RHCs in a reasonably similar geographic area with respect to relevant social, health care, and economic characteristics. If the facility is unable to identify three comparable FQHCs or RHCs, DHS will identify at least three comparable facilities with respect to relevant social, health care, and economic characteristics.

3. At a new facility's one time election, DHS will establish a rate (calculated on a per visit basis) that meets the requirements of Section 1902(bb)(4) of the Act and that is equal to one of the following:

   (a) The average of the rates established for the three comparable FQHCs or RHCs, as verified by DHS from information submitted as required under paragraph J.2. The prospective payment reimbursement rate established under this subparagraph will be subject to the annual MEI increases as described in paragraph D.4.

(b) Reimbursement at 100 percent of the projected allowable costs of the facility for furnishing services in the facility's first full fiscal year of the facility's operation at the new site. The projected allowable costs for the first fiscal year will be cost settled and the prospective payment reimbursement rate will be based on actual cost per visit. The prospective payment reimbursement rate, so established, will apply retrospectively to all services provided at the new site. After the facility's first fiscal year of operations at the new site, the prospective payment reimbursement rate established under this subparagraph, which is based on the projected allowable costs, will be subject to the annual MEI increases described in paragraph D.4.

4. If a new facility does not respond within 30 days of DHS' request for three comparable FQHCs or RHCs as described in subparagraph J.3(a) or the projected allowable costs as described in subparagraph J.3(b), DHS will suspend processing of the new facility's request for reimbursement as an FQHC or RHC, until the required information has been provided.

5. The effective date for the rate of a new facility under Section J is retroactive to the later of the date that the licensed FQHC or RHC was federally qualified as an FQHC or RHC, or the date a new FQHC or RHC at a new location was added to an existing FQHC or RHC as a licensed or enrolled Medi-Cal provider.

   (a) An FQHC or RHC may continue billing for Medi-Cal covered benefits on a fee-for-service basis under its existing provider number until it is informed of its new FQHC or RHC provider number. Until its FQHC or RHC provider number is received, a facility must not bill the Medi-Cal program using the FQHC or RHC provider number of another facility. The preceding sentence will not apply to intermittent service sites that are affiliated with an FQHC or RHC and that operate less than 20 hours per week or in mobile facilities.

   (b) DHS will reconcile the difference between the fee-for-service payments and the FQHC's or RHC's PPS rate following notification to the provider that its FQHC or RHC number has been activated.

6. In order to establish comparable FQHCs or RHCs providing similar services, DHS will require all FQHCs or RHCs to submit to DHS either of the following:

(a) Its most recent annual utilization report as submitted to the Office of Statewide Health Planning and Development, unless the FQHC or RHC was not required to file an annual utilization report.

(b) A similar report utilizing a format as specified by DHS applicable to the prior calendar year.

FQHCs or RHCs that have experienced changes in their services or caseload subsequent to the filing of the annual utilization report may submit a completed report in the format used in the prior calendar year. A new FQHC or RHC that has not previously submitted an annual utilization report will submit an annual utilization report or similar report as specified by DHS.

K. Scope-of-Service Rate Adjustments

An FQHC or RHC may apply for an adjustment to its per-visit rate based on a change in the scope-of-services provided by the FQHC or RHC, subject to all of the following:

1. A change in costs, in and of itself, will not be considered a scope-of-service change unless all of the following apply:

   (a) The increase or decrease in cost is attributable to an increase or decrease in the scope of the services defined in paragraph C.1.

   (b) The cost is allowable under Medicare reasonable cost principles set forth in 42 CFR Part 413.

   (c) The change in the scope-of-services is a change in the type, intensity, duration, or amount of services, or any combination thereof.

   (d) The net change in the FQHC's or RHC's per-visit rate equals or exceeds 1.75 percent for the affected FQHC or RHC site. For FQHCs or RHCs that filed consolidated cost reports for multiple sites to establish the initial prospective payment reimbursement rate, the 1.75 percent threshold will be applied to the average per-visit rate of all sites for the purposes of calculating the cost associated with a scope-of-service change. "Net change" means the per-visit rate change attributable to the cumulative effect of all increases and decreases for a particular fiscal year.

2. Rate changes based on a change in the scope-of-services provided by an FQHC or RHC will be evaluated in accordance with Medicare reasonable cost principles, as set forth in 42 CFR Part 413, or its successor. Subject

to the conditions set forth in subparagraphs (a) through (d), inclusive, of paragraph (1), a change in scope-of-service means any of the following:

(a) The addition of a new FQHC or RHC service (such as adding dental services, another health professional service, or other Medi-Cal covered services that do not require a face-to-face visit with an FQHC or RHC provider, for example, laboratory, x-rays) that is not included in the existing prospective payment system reimbursement rate, or the deletion of an FQHC or RHC service (such as deleting dental services, another health professional service, or other Medi-Cal covered services that do not require a face-to-face visit with an FQHC or RHC provider, for example, laboratory, x-rays) that is included in the existing prospective payment system reimbursement rate.

(b) A change in service described in paragraph C.1 due to amended regulatory requirements or rules.

(c) A change in service described in paragraph C.1 resulting from either remodeling an FQHC or RHC, or relocating an FQHC or RHC if it has not elected to be treated as a newly qualified clinic under Section F.

(d) A change in types of services described in paragraph C.1 due to a change in applicable technology and medical practice utilized by the center or clinic.

(e) An increase in the intensity of a service described in paragraph C.1 attributable to changes in the types of patients served, including, but not limited to, populations with HIV or AIDS, or other chronic diseases, or homeless, elderly, migrant, or other special populations.

(f) Changes in any of the services described in paragraph C.1, or in the provider mix of an FQHC or RHC or one of its sites.

(g) Changes in operating costs attributable to capital expenditures associated with a modification of the scope of any of the services described in paragraph C.1, including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the center or clinic.

(h) Costs incurred by an FQHC or RHC for indirect medical education adjustments and any direct graduate medical education payment necessary for providing teaching services to interns and residents

at the FQHC or RHC that are associated with a modification of the scope of any of the services described in paragraph C.1.

(i) A change in the scope of a project approved by HRSA where the change impacts a covered service described in paragraph C.1.

3. An FQHC or RHC may submit a request for scope-of-service changes once per fiscal year, within 150 days of the beginning of the FQHC's or RHC's fiscal year following the year in which the change occurred. Any approved increase or decrease in the provider's rate will be retroactive to the beginning of the FQHC's or RHC's fiscal year in which the request is submitted.

4. An FQHC or RHC must submit a scope-of-service rate change request within 150 days of the beginning of any FQHC's or RHC's fiscal year occurring after the effective date of this Section K, if, during the FQHC's or RHC's prior fiscal year, the FQHC or RHC experienced a decrease in the scope-of-services provided that the FQHC or RHC either knew or should have known would have resulted in a significantly lower per-visit rate. If any FQHC or RHC discontinues providing onsite pharmacy or dental services, it must submit a scope-of-service rate change request within 150 days of the beginning of the fiscal year following the year in which the change occurred. As used in this paragraph, "significantly lower" means an average per-visit rate decrease in excess of 2.5 percent.

5. Notwithstanding paragraph K.4, if the approved scope-of-service change or changes were initially implemented on or after the first day of an FQHC's or RHC's fiscal year ending in calendar year 2001, but before the adoption and issuance of written instructions for applying for a scope-of-service change, the adjusted reimbursement rate for that scope-of-service change will be made retroactive to the date the scope-of-service change was initially implemented. Scope-of-service changes under this paragraph must be submitted within 150 days after the adoption and issuance of the written instructions by DHS.

6. The reimbursement rate for scope-of-service changes implemented within the FQHC's or RHC's fiscal year ending in calendar year 2004 and subsequent fiscal years will be calculated as follows:

(a) If DHS determines that documentation submitted by the FQHC or RHC accurately reflects the cost per-visit rate calculation for that particular year, DHS will subtract the current PPS per-visit rate from the newly calculated per-visit rate for that particular year. The "current PPS per-visit rate" means the PPS per-visit rate in effect on the last day of the reporting period during which the scope-of-service change occurred.

(b) The difference computed as in 6(a), between the newly calculated cost per-visit rate and the current PPS per-visit rate, is then multiplied by an 80 percent adjustment factor to arrive at an amount that is to be considered applicable to a scope-of-service adjustment for that year.

(c) That 80 percent adjustment amount is then added to the current PPS rate and the newly established rate becomes the newly adjusted PPS reimbursement rate, effective the first day following the fiscal year end that the FQHC or RHC submitted the documentation for the scope-of-service change. For example, a FQHC or RHC has a:

(i) Newly established per-visit rate of $115.00,

(ii) Current PPS per-visit rate of $95.00,

(iii) July 1, 2003, to June 30, 2004, fiscal year and a

(iv) Scope-of-service change date of February 15, 2004.

The newly established PPS rate is calculated and effective as follows:

(v) $20.00 is the difference between the newly established per-visit rate ($115.00) and the current PPS rate ($95.00),

(vi) $16.00 is the 80 percent adjustment amount ($20.00 X 80 percent),

(vii) $111.00 is the newly established PPS rate ($95.00 + $16.00),

(viii) July 1, 2004, is the date the $111.00 rate becomes effective.

(ix) The MEI will be applied to the PPS rate established in calendar year 2004 and subsequent fiscal years on the first day of October that is not within the particular FQHC's or RHC's fiscal year. For any FQHC or RHC that has a July 1, 2003, to June 30, 2004, fiscal year (as described in the example above), October 1, 2004, is the date of the MEI, which will be applied to the July 1, 2004, established PPS rate. For any FQHC or RHC that has a January 1, 2004 to December 31, 2004, fiscal year, October 1, 2005, is the

date the MEI will be applied to the January 1, 2005, established PPS rate.

(d) For scope-of-service changes implemented between the first day of an FQHC's or RHC's fiscal year ending in calendar year 2001 and the last day of the FQHC's or RHC's fiscal year ending in calendar year 2003, the reimbursement rate will be calculated by taking the difference between the newly established per-visit rate and the initial PPS rate, then multiplying the difference by 80 percent for either two or three periods, depending on when the scope-of-service change occurred and when the cost report is filed. For example, an FQHC or RHC has a:

(i) Newly established per-visit rate of $120.00,

(ii) Initial PPS rate of $95.00,

(iii) July 1, 2002, to June 30, 2003, fiscal year, and

(iv) Scope-of-service change date of February 15, 2001.

Then the retroactive PPS rate for the fiscal years in question is calculated and becomes effective as follows:

(v) $25.00 is the difference between the newly established per-visit rate ($120.00) and the initial PPS rate ($95.00),

(vi) $20.00 is the 80 percent adjustment amount ($25.00 X 80%) for the July 1, 2002, to June 30, 2003, period, is added to the initial PPS rate for a PPS rate of $115.00 ($95.00 + $20.00), and is effective July 1, 2002, to September 30, 2003,

(vii) $16.00 is the 80 percent adjustment factor ($20.00 X 80%) for the July 1, 2001, to June 30, 2002, period, is added to the initial PPS rate for a PPS rate of $111.00 ($95.00 + $16.00), and is effective July 1, 2001, to June 30, 2002,

(viii) $12.80 is the 80 percent adjustment amount ($16.00 X 80%) for the January 1, 2001, to June 30, 2001, period, is added to the initial PPS rate for a PPS rate of $107.80 ($95.00 + $12.80), and is effective February 15, 2001, to June 30, 2001.

(ix) The MEI will be applied to the PPS rate established in calendar 2003 on the first day of October that is not within

the particular FQHC's or RHC's 2003 fiscal year. For any FQHC or RHC that has a July 1, 2002, to June 30, 2003, fiscal year (as described in the example above), October 1, 2003, is the date of the MEI, which will be applied to the July 1, 2002, to September 30, 2003, established PPS rate. For any FQHC or RHC that has a January 1, 2003, to December 31, 2003, fiscal year, October 1, 2004, is the date the MEI will be applied to the January 1, 2003, established PPS rate.

7. A written request under Section K must be made to DHS and include differences in costs and visits, if applicable, associated with scope-of-service change(s), utilizing a cost report format as specified by DHS. Costs must not be reported twice for duplicate reimbursement. Costs arising from extraordinary circumstances and for which the FQHC or RHC has either been reimbursed or for which supplemental reimbursement is pending under Section G will not be reimbursable as a scope-of-service rate change under either Sections F or K.

8. Rate adjustments for scope-of-service changes under this Section K for an FQHC's or RHC's fiscal year ending in 2004, were deemed to have been filed in a timely manner so long as they were filed within 90 days following the end of the 150 day timeframe applicable to retroactive scope-of-service changes occurring from January 1, 2001, to the end of an FQHC's or RHC's 2003 fiscal year or the date the scope-of-service forms are received, whichever is later.

L. Administration of Managed Care Contracts

1. Where an FQHC or RHC furnishes services pursuant to a contract with a managed care entity (MCE) (as defined in Section 1932(a)(1)(B) of the Act), DHS will make supplemental payments to the extent required by Section 1902(bb)(5) of the Act.

2. Supplemental payments made pursuant to paragraph L.1. will be governed by the provisions of subparagraph (a) through (d), below.

   (a) FQHCs and RHCs that provide services under a contract with a MCE will receive, at least quarterly, state supplemental payments for such services that are an estimate of the difference between the payments the FQHC or RHC receives from MCEs and the payments the FQHC or RHC would have received under the methodology described in Section D, E, or J, and, if applicable, Section F.

(b) At the end of each FQHC's or RHC's fiscal year, the total amount of supplemental and MCE payments received by the FQHC or RHC will be reviewed against the amount that the actual number of visits provided under the FQHC's or RHC's contract with MCEs would have yielded under the methodology described in Section D, E, or J, and, if applicable, Section G.

(c) If the amount calculated under the methodology described in Section D, E, or J, and, if applicable, Section G exceeds the total amount of supplemental and MCE payments, the FQHC or RHC will be paid the difference between the Section D, E, or J, and, if applicable, Section G amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received by the FQHC or RHC.

(d) If the amount calculated using the methodology described in Section D, E, or J, and, if applicable, Section G is less than the total amount of supplemental and MCE payments, the FQHC or RHC will refund the difference between the amount calculated using the methodology described in Section D, E, or J, and, if applicable, Section G (based on actual visits) and the total amount of supplemental and MCE payments received by the FQHC or RHC.

3. Payments made to any FQHC or RHC for FQHC or RHC services under managed care contracts, as described in paragraphs 1 and 2 of this Section L, will exclude any financial incentive payments to the FQHC or RHC that are required by federal law to be excluded from the calculation described in paragraph L.2.

M. Payment for Services for Recipients with Medicare/Medi-Cal or Child Health and Disability Prevention (CHDP) Program Coverage

1. Where a recipient has coverage under the Medicare or the CHDP program, DHS will supplement the payment from those programs not to exceed the prospective payment reimbursement rates established under this Amendment.

2. Where an FQHC or RHC services are partially reimbursed by a third party such as CHDP, DHS will reimburse an FQHC or RHC for the difference between its per-visit PPS rate and receipts from other plans or programs on a contract-by-contract basis and not in the aggregate. Such reimbursement may not include managed care financial incentive payments that are required by federal law to be excluded from the calculation.

N. Alternative Payment Methodology for FQHCs and RHCs that Elect to Provide Dental Hygienist Services or Dental Hygienist in Alternative Practice Services as a Billable Visit

1. An FQHC or RHC may, on or after January 1, 2008, elect to provide the services of a dental hygienist or dental hygienist in alternative practice as a separate and discreet "billable visit" under an alternative payment methodology (APM). Multiple encounters with dental professionals that take place on the same day will constitute a single visit. For purposes of this Section N, the term "dental hygienist in alternative practice" means a person licensed pursuant to Section 1774 of the California Business and Professions Code.

2. An FQHC or RHC has an option to provide dental hygienist services or dental hygienist in alternative practice services as a billable visit, in the following situations:

   (a) For those FQHCs or RHCs that have the cost of dental hygienist services or dental hygienist in alternative practice services included in their PPS reimbursement rate on or before January 1, 2008, and continue to provide those services, the FQHC or RHC may elect to have these services billed as a billable visit under this Section N. However if the APM total reimbursement results in an amount that is less (in the aggregate -- defined in paragraph N.2(c)) than under the methodology described in Section D, E, F, I, J, or K, whichever is applicable, then the FQHC or RHC will be compensated in accordance with the reconciliation process as defined in paragraph N.2.(e) below.

   If an FQHC or RHC requests the APM, including separate billable visits, the FQHC or RHC must submit appropriate form(s) as prescribed by DHCS in order for DHCS to recalculate the PPS reimbursement rate to an APM reimbursement rate described in this Section N. The recalculated reimbursement rate will include the services of a dental hygienist or dental hygienist in alternative practice as a billable visit.

   An FQHC or RHC that elects to have its PPS reimbursement rate recalculated under an APM reimbursement rate pursuant to this paragraph N.2 may continue to bill for all other FQHC or RHC visits at its existing per-visit PPS reimbursement rate, subject to reconciliation, until the rate adjustment for visits between an FQHC or RHC patient and a dental hygienist or dental hygienist in alternative practice has been approved. Any approved APM reimbursement rate shall be calculated within six months after the date that DHCS receives the FQHC's or RHC's form(s) as prescribed by DHCS. DHCS will also complete a revenue reconciliation (defined in paragraph N.2(e)) of the approved APM reimbursement rate to ensure that the APM total reimbursement results in an amount that is no less (in the aggregate -- defined in paragraph N.2 (c)) than what the FQHC or RHC would have received under the methodology described in Section D, E, F, I, J, or K, whichever is applicable. An approved APM reimbursement rate will be retroactive to the beginning of the fiscal year in which the FQHC or RHC submits the request, but in no case will the effective date be earlier than January 1, 2008.

No scope-of-service change request for dental hygienist services or dental hygienist in alternative practice services will be considered for an FQHC or RHC that elects the APM reimbursement rate pursuant to this paragraph N.2(a).

(b) If an FQHC or RHC did not provide the services of a dental hygienist or dental hygienist in alternative practice before January 1, 2008, and later adds these services, a scope-of-service change may be requested as provided in Section K. After a scope-of-service change to add the additional service has been calculated and the PPS reimbursement rate has been revised to include the new service, an FQHC or RHC may elect the option to have dental hygienist services or dental hygienist in alternative practice services be reimbursed as a billable visit under the APM described in this Section N.

(c) For purposes of this Section N, "in the aggregate" when referenced with respect to the APM, is defined as the total revenue a facility would receive, calculated by multiplying the applicable reimbursement rate by the total number of services provided by dental hygienist or dental hygienist in alternative practice services in a given year and adding that revenue to the PPS reimbursement rate multiplied by the total number of services provided in given year that are compensated using the PPS reimbursement rate.

(d) For purposes of this Section N, "in the aggregate" when referenced with respect to the reimbursement rate under Section D, E, F, I, J, or K is defined as the total reimbursement which an FQHC or RHC would have been received using a PPS reimbursement rate (which does not include the services of a dental hygienist or dental hygienist in alternative practice as separate, billable visits) multiplied by the total number of services provided in a given year that are compensated using the PPS reimbursement rate.

(e) If the estimated total aggregate revenue for an FQHC or RHC under paragraph (d) above is greater than what the FQHC or RHC received in accordance with paragraph (c) above, DHCS will reimburse an FQHC or RHC for the difference between the amount it received in accordance with paragraph (c) above and the amount it would have received in accordance with paragraph (d) above. This process applies to the circumstance described in the first paragraph of paragraph N.2(a).

3. For FQHCs or RHCs that fall under one of the circumstances described in subparagraph N.2(a) or (b) above, and elect readjustment of their reimbursement rate under this Section N, DHCS shall recalculate the rate and make the appropriate rate adjustment as an APM as long as the FQHC or RHC agrees to the APM reimbursement rate and if the APM results in a total reimbursement that is no less (in the aggregate) than what the FQHC or RHC would have received under the methodology described in Section D, E, F, I, J, or K, whichever is applicable. In circumstances where the APM results in a total reimbursement that is less than what the FQHC or RHC would have received under Section D, E, F, I, J, or K, whichever is applicable, DHCS will complete a revenue reconciliation as described in paragraph N.2.(d).

O. Additional Provisions Regarding Multiple Encounters

In addition to the multiple encounters as provided in paragraph C.3(b), more than one visit may be counted on the same day when the FQHC or RHC patient has a face-to-face encounter with a dental hygienist, or dental hygienist in alternative practice, and then also has a face-to-face encounter with any non-dental health provider, as provided in paragraph C.3(b). Multiple encounters with a dentist and a dental hygienist or dental hygienist in alternative practice that take place on the same day will constitute a single visit.

P. Scope of Service Rate Adjustments for Marriage and Family Therapist

1. If an FQHC or RHC does not provide Marriage and Family Therapy Services, but wishes to add the service, the following shall apply:

   Notwithstanding Section K, an FQHC or RHC shall submit a change in scope of services request in order to add and bill for services provided by Marriage and Family Therapists (MFTs). The FQHC or RHC must add the MFT service for a full fiscal year (12 months) before it can submit a change in scope of service request. Rate changes based on a change in the scope of services provided by an FQHC or RHC shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor. After the FQHC or RHC adds MFT services for a full fiscal year, the FQHC or RHC may request a change in scope within 150 days following the beginning of the FQHC's or RHC's fiscal year. Any approved increase or decrease in the provider's rate shall be retroactive to the beginning of the FQHC's or RHC's fiscal year in which the request is submitted.

2. Notwithstanding Section K, if an FQHC's or RHC's PPS rate currently includes the cost of MFT services, and the FQHC or RHC elects to bill MFT services as a separately reimbursable PPS visit, it shall apply for an adjustment to its PPS rate by utilizing the change in scope of services request forms to determine the FQHC's of RHC's rate within 150 days following the beginning of the FQHC's or RHC's fiscal year. The rate adjustment request must include one full fiscal year (12 months) of MFT costs and visits. DHCS' approval of a rate adjustment pursuant to this subparagraph shall not constitute a change in scope of services within the meaning of Section K. Rate changes based on an FQHC's or RHC's application for a rate adjustment, and DHCS's reconciliation of costs and visits shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

MAXIMUM STATEWIDE PAYMENT RATES -- FY 1997-98

| Procedure Code | Procedure Description | Rate |
|---|---|---|
| A. PEDIATRIC PRACTITIONER SERVICES: | | |
| 99201 | OFFICE VISIT, NEW, LEVEL 1 | 18.40 |
| 99202 | OFFICE VISIT, NEW, LEVEL 2 | 27.60 |
| 99203 | OFFICE VISIT, NEW, LEVEL 3 | 46.00 |
| 99204 | OFFICE VISIT, NEW, LEVEL 4 | 55.38 |
| 99205 | OFFICE VISIT, NEW, LEVEL 5, ADULT | 64.40 |
| 99205 | OFFICE VISIT, NEW, LEVEL 5, ADOLESCENT | 50.50 |
| 99205 | OFFICE VISIT, NEW, LEVEL 5, LATE CHILDHOOD | 40.40 |
| 99205 | OFFICE VISIT, NEW, LEVEL 5, EARLY CHILDHOOD | 30.30 |
| 99205 | OFFICE VISIT, NEW, LEVEL 5, INFANT | 25.25 |
| 99211 | OFFICE VISIT, EST., LEVEL 1 | 7.36 |
| 99212 | OFFICE VISIT, EST., LEVEL 2 | 11.04 |
| 99213 | OFFICE VISIT, EST., LEVEL 3 | 16.56 |
| 99214 | OFFICE VISIT, EST., LEVEL 4 | 27.60 |
| 99215 | OFFICE VISIT, EST., LEVEL 5, ADULT | 46.00 |
| 99215 | OFFICE VISIT, EST., LEVEL 5, ADOLESCENT | 40.40 |
| 99215 | OFFICE VISIT, EST., LEVEL 5, LATE CHILDHOOD | 30.30 |
| 99215 | OFFICE VISIT, EST., LEVEL 5, EARLY CHILDHOOD | 25.25 |
| 99215 | OFFICE VISIT, EST., LEVEL 5, INFANT | 20.20 |
| 99241 | OFFICE CONSULTATION, LEVEL 1 | 24.60 |
| 99242 | OFFICE CONSULTATION, LEVEL 2 | 24.60 |
| 99243 | OFFICE CONSULTATION, LEVEL 3 | 41.00 |
| 99244 | OFFICE CONSULTATION, LEVEL 4 | 57.40 |
| 99245 | OFFICE CONSULTATION, LEVEL 5 | 57.40 |
| 99271 | CONFIRMATORY CONSULTATION, LEVEL 1 | 24.60 |
| 99272 | CONFIRMATORY CONSULTATION, LEVEL 2 | 24.60 |
| 99273 | CONFIRMATORY CONSULTATION, LEVEL 3 | 41.00 |
| 99274 | CONFIRMATORY CONSULTATION, LEVEL 4 | 57.40 |
| 99275 | CONFIRMATORY CONSULTATION, LEVEL 5 | 57.40 |
| 99341 | HOME VISIT, NEW, LEVEL 1 | 33.12 |
| 99342 | HOME VISIT, NEW, LEVEL 2 | 42.32 |
| 99343 | HOME VISIT, NEW, LEVEL 3 | 53.36 |
| 99351 | HOME VISIT, EST., LEVEL 1 | 17.48 |
| 99352 | HOME VISIT, EST., LEVEL 2 | 28.52 |
| 99353 | HOME VISIT, EST., LEVEL 3 | 34.96 |
| 99354 | PROL PHYSICIAN SERV IN OFFICE/OTHER OUTP | 33.92 |
| 99355 | PROL PHYSICIAN SERV IN OFFICE/OTHER OUTP | 15.76 |
| 99358 | PROL EVAL AND MANAGEMENT SERV BEFORE AND | Non Benefit |
| 99359 | PROL EVAL AND MANAGEMENT SERV BEFORE AND | Non Benefit |
| 99381 | PREVENTIVE MED., NEW, INFANT | 24.24 |
| 99382 | PREVENTIVE MED., NEW, 1-4 YRS. | 32.32 |
| 99383 | PREVENTIVE MED., NEW, 5-11 YRS. | 40.40 |
| 99384 | PREVENTIVE MED., NEW, 12-17 YRS. | 48.48 |
| 99391 | PREVENTIVE MED., EST., INFANT | 20.20 |
| 99392 | PREVENTIVE MED., EST., 1-4 YRS. | 24.24 |
| 99393 | PREVENTIVE MED., EST., 5-11 YRS. | 32.32 |
| 99394 | PREVENTIVE MED., EST., 12-17 YRS. | 40.40 |

MAXIMUM STATEWIDE PAYMENT RATES -- FY 1997-98

| Procedure Code | | Procedure Description | Rate |
|---|---|---|---|
| 99401 | | COUNSELING, INDIVIDUAL, 15 MIN. | Non Benefit |
| 99402 | | COUNSELING, INDIVIDUAL, 30 MIN. | Non Benefit |
| 99403 | | COUNSELING, INDIVIDUAL, 45 MIN. | Non Benefit |
| 99404 | | COUNSELING, INDIVIDUAL, 60MIN. | Non Benefit |
| 99411 | | COUNSELING, GROUP 30 MIN. | Non Benefit |
| 99412 | | COUNSELING, GROUP, 60 MIN. | Non Benefit |
| 99420 | | HEALTH RISK APPRAISAL | Non Benefit |
| 99429 | | UNLISTED PREVENTIVE MED. | By Report |
| 99432 | | NEWBORN CARE, OUTSIDE HOSPITAL | 55.20 |
| X5332 | (90700) | DTAP IMMUNIZATION | 24.32 |
| X5312 | (90701) | DIPTHERIA/TETANUS TOXOID/PERTUSSIS-0.5ML | 19.76 |
| X5310 | (90702) | DIPTHERIA/TETANUS TOXOID ADSORBED-0.5ML | 9.43 |
| X6954 | (90703) | TETNUS TOXOID, ABSORBED - 0.5ML | 9.43 |
| X5324 | (90704) | MUMPS VIRUS VACCINE LIVE SINGLE DOSE | 24.15 |
| X5300 | (90705) | MEASLES(RUBEOLA VIRUS VACCINE-LIVE | 19.79 |
| X5322 | (90706) | RUBELLA VIRUS VACCINE-LIVE SINGLE DOSE | 23.00 |
| X5320 | (90707) | MEASLES/MUMPS/RUBELLA VIRUS VACCINE LIVE | 36.77 |
| X5318 | (90708) | MEASLES(RUBEOLA)RUBELLA VIRUS VACCINE | 29.00 |
| X5302 | (90709) | RUBELLA/MUMPS VIRUS VACCINE LIVE SGL DOS | 30.52 |
| 90749 | (90710) | MEASLES/MUMPS/RUBELLA VACCINE VARICELLA | By Report |
| 90749 | (90711) | DTP and INJECTABLE POLIO | By Report |
| X5326 | (90712) | ORIMUNE DISPETTES - 0.5CC EA | 18.98 |
| X5328 | (90712) | ORIMUNE - 2 DROP DOSE/VIAL | 16.17 |
| X6774 | (90713) | POLIOMYELITIS VACCINE - 1CC AMP | 27.44 |
| X6990 | (90714) | TYPHOID VACCINE-5 ML | 9.43 |
| X7106 | (90716) | VARICELLA | 47.44 |
| X7024 | (90717) | YELLOW FEVER VAC-YELLOW FEVER VAC CONNAU | 9.19 |
| X6100 | (90719) | DIPTHERIA TOXOID ADSORBED(PED-5ML | 9.43 |
| X5321 | (90720) | TETRAMUNE VACCINE 0.5CC DPT/HIB | 33.63 |
| 90749 | (90721) | DIPHTHERIA,TETANUS,and ACELLULAR PERTUSSIS (DTaP) AND HEMOPHILUS INFLUENZA B (HIB) VACCINE | By Report |
| X6218 | (90724) | INFLUENZA VIRUS VACCINE(ADULT)0.5ML | 11.61 |
| X5938 | (90725) | CHOLERA VACCINE-1.5ML | 9.89 |
| X5936 | (90725) | CHOLERA VACCINE-20ML | 8.49 |
| 90726 | (90726) | RABIES IMMUNIZATION | By Report |
| X6770 | (90727) | PLAGUE VACCINE-2 ML | 12.99 |
| X6768 | (90727) | PLAGUE VACCINE-20 ML | 8.69 |
| X5730 | (90728) | BCG VACCINE, PERCUTANEOUS | 8.79 |
| 90749 | (90730) | HEPATITIS A VACCINE | By Report |
| X6772 | (90732) | PNEUMOCOCCAL VACCINE-0.5 ML | 14.59 |
| X6542 | (90733) | MENINGOCOCCAL POLYSACCHARIDE-GROUP A 10 | 8.49 |
| X6270 | (90737) | HAEMOPHILUS INFLUENZAE VACCINE HIB TITER | 22.00 |
| X6268 | (90737) | H. INFLUENZAE B VACCINE--0.5ML | 14.35 |
| X6272 | (90737) | H. INFL. VACCINE(PROHIBIT) 0.5 ML. | 23.50 |
| X6232 | (90741) | IMMUNE SERUM GLOBULIN-HUMAN-2ML | 10.26 |
| X6230 | (90741) | IMMUNE SERUM GLOBULIN-1ML | 5.95 |

MAXIMUM STATEWIDE PAYMENT RATES -- FY 1997-98

| Procedure Code | | Procedure Description | Rate |
|---|---|---|---|
| | | Specific Hyperimmune Serum Globulin: | |
| X6346 | (90742) | MUMPS IMMUNE GLOBULIN(HUMAN-1.5ML | 9.99 |
| X6344 | (90742) | MUMPS IMMUNE GLOBULIN(HUMAN-4.5ML | 9.19 |
| X6348 | (90742) | PERTUSSIS IMMUNE GLOBULIN(HUMAN)1.25ML | 20.19 |
| X6280 | (90742) | HEPATITIS B IMMUNE GLOBULIN(HUMAN)3ML | 47.49 |
| X6278 | (90742) | HEPATITIS B IMMUNE GLOBULIN(HUMAN)4ML | 47.49 |
| X6276 | (90742) | HEPATITIS B IMMUNE GLOBULIN(HUMAN)5ML | 39.59 |
| X5676 | (90742) | TETANOS IMMUNE GLOBULIN(HUMAN)250 UNIT | 8.53 |
| X6098 | (90742) | RHO(D)IMMUNE GLOBLIN(HUMAN) | 50.24 |
| X6350 | (90742) | MICRO-GAM | 33.04 |
| X7088 | (90744) | ENGERIX-B (PEDIATRIC) 10.0 MCG/0.5 ML. | 30.95 |
| X7092 | (90744) | RECOMBIVAX HB (PEDIATRIC) 2.5 MCG/0.5 ML | 25.50 |
| X7098 | (90744) | RECOMBIVAX HB (PEDIATRIC) 15.0 MCG/3.0 ML | 39.83 |
| X7090 | (90745) | ENGERIX-B (ADULT TO 19 YEARS) 20.0 MCG/1.0 ML. | 61.85 |
| X7096 | (90745) | RECOMBIVAX HB (ADULT) 10.0 MCG/1.0 ML | 53.64 |
| X7100 | (90745) | RECOMBIVAX HB (ADULT) 30.0 MCG/3.0 ML | 53.64 |
| 90749 | (90749) | UNLISTED IMMUNIZATION, Including 90710, 90711, 90716, 90730 | By Report |

B. OBSTETRICAL PRACTITIONER SERVICES:

| | | |
|---|---|---|
| 59000 | AMNIOCENTESIS | 50.67 |
| 59012 | FETAL CORD PUNCTURE PRENATAL | 132.25 |
| 59015 | CHORION BIOPSY | Non Benefit |
| 59020 | FETAL CONTRACTION STRESS TEST | 50.67 |
| 59025 | FETAL NON-STRESS TEST | 20.27 |
| 59030 | FETAL SCALP BLOOD SAMPLE | 50.67 |
| 59050 | FETAL MONITOR DURING LABOR BY CONS PHYSI | 81.07 |
| 59051 | FETAL MONITORING DURING LABOR BY CONSULT | 74.48 |
| 59100 | REMOVE UTERUS LESION | 709.38 |
| 59120 | TREAT ECTOPIC PREGNANCY | 709.38 |
| 59121 | TREAT ECTOPIC PREGNANCY | 709.38 |
| 59130 | TREAT ECTOPIC PREGNANCY | By Report |
| 59135 | TREAT ECTOPIC PREGNANCY | 841.12 |
| 59136 | TREAT ECTOPIC PREGNANCY | 841.12 |
| 59140 | TREAT ECTOPIC PREGNANCY | By Report |
| 59150 | TREAT ECTOPIC PREGNANCY | 385.09 |
| 59151 | TREAT ECTOPIC PREGNANCY | 385.09 |
| 59160 | D&C AFTER DELIVERY | 202.68 |
| 59200 | INSERTION OF CERVICAL DILATOR | Non Benefit |
| 59300 | EPISIOTOMY OR VAGINAL REPAIR | 101.34 |
| 59320 | REVISION CERVIX | By Report |
| 59325 | REVISION CERVIX | By Report |
| 59350 | REPAIR OF UTERUS | 699.25 |
| 59400 | OBSTETRICAL CARE | 961.20 |
| 59409 | VAG DELIVERY ONLY (WITH OR W/OUT EPISIOT | 480.60 |
| 59410 | VAGINAL DELIVERY ONLY | Non Benefit |
| 59412 | ANTEPARTUM MANIPULATION | Non Benefit |

MAXIMUM STATEWIDE PAYMENT RATES -- FY 1997-98

| Procedure Code | Procedure Description | Rate |
|---|---|---|
| 59414 | DELIVER PLACENTA | By Report |
| 59425 | ANTEPARTUM CARE ONLY | Non Benefit |
| 59426 | ANTEPARTUM CARE ONLY | Non Benefit |
| 59430 | CARE AFTER DELIVERY | Non Benefit |
| 59510 | CESAREAN DELIVERY | 961.27 |
| 59514 | CESAREAN DELIVERY ONLY | 480.64 |
| 59515 | CESAREAN DELIVERY | Non Benefit |
| 59525 | RML UTERUS AFTER CESAREAN | 211.15 |
| 59812 | TREATMENT OF MISCARRAIGE | 148.92 |
| 59820 | CARE OF MISCARRIAGE | 148.92 |
| 59821 | TREATMENT OF MISCARRIAGE | 148.92 |
| 59830 | TREAT UTERUS INFECTION | By Report |
| 59840 | ABORTION | 158.10 |
| 59841 | ABORTION | 223.38 |
| 59850 | ABORTION | 206.76 |
| 59851 | ABORTION | 206.76 |
| 59852 | ABORTION | 521.22 |
| 59855 | INDUCED ABORTION BY ONE/MORE VAG/SUPP | 178.85 |
| 59856 | INDUCED ABORTION BY ONE/MORE VAG/SUPP | 258.11 |
| 59857 | INDUCED ABORTION BY ONE/MORE VAG/SUPP | 589.35 |
| 59870 | EVACUATE MOLE UTERUS | 304.02 |
| 59899 | MATERNITY CARE PROCEDURE | By Report |

MEDI-CAL PROGRAM
OBSTETRICAL PRACTITIONER PARTICIPATION

| FIELD OFFICE DISTRICT | (1) AVAILABLE OBSTETRICAL PRACTITIONERS | (2) PARTICIPATING OBSTETRICAL PRACTITIONERS | (3) PERCENT PARTICIPATION |
|---|---|---|---|
| Oakland | 614 | 385 | 62.70 |
| Sacramento | 902 | 723 | 80.16 |
| San Francisco | 645 | 457 | 70.85 |
| Fresno | 625 | 655 | 104.80 |
| San Diego | 805 | 593 | 73.66 |
| San Bernardino | 654 | 561 | 85.78 |
| Los Angeles | 2,534 | 2362 | 93.21 |
| San Jose | 629 | 356 | 56.60 |
| Total | 7,408 | 6,092 | 82.24 |

(1) Number of nonfederal office-based obstetricians, gynecologists, and family practitioners during calendar year 1996. SOURCE: American Medical Association (AMA), provided by special request.

(2) Fee-for-service obstetricians, gynecologists, and family practitioners paid during calendar year 1996, weighted for group practices. Previous analysis of "rendering providers" in group practice settings reflect an average of 2.52 physicians per family practice group, and 3.51 physicians per obstetrics/gynecology group.

(3) Percentages which exceed 100 indicate potential flaws in the database used for this table. Possible explanations include: a) a Medi-Cal physician could be double-counted if moving during the year from a private practice to a group practice; b) the statewide average number of physicians in group settings may be higher than the actual number for that county; or c) the AMA data may incompletely count office-based physicians.

Note: Data for the counties of Orange, San Mateo, Santa Barbara, Santa Cruz and Solano counties were excluded from this analysis because of the existence of county operated capitation programs and Geographic Managed Care arrangements.